

FILED MAR 3 1948

Registration District No. 2

Primary Registration District No. 5110

1. PLACE OF DEATH:

(a) County BOLLINGER
(b) City or town RURAL ELLMORE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)
In this community 2 1/2 YEARS
years, months or days

3. (a) PRINT FULL NAME BENJAMIN F. COUNCE

3. (b) If veteran, name war 494-03 3. (c) Social Security 66521

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife DELLA COUNCE 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased MARCH 21 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 11 26 hr. min.

9. Birthplace DE SOTO ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business.

MOTHER FATHER { 12. Name Joseph Counce
13. Birthplace Tenn.
14. Maiden name Lucy Counce
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Ike Counce
(b) Address 5631 Wilbur Drive, St. Louis

17. (a) (Burial, cremation, or removal) (b) Date thereof Feb. 20 1948
(Month) (Day) (Year)

(c) Place: burial or cremation Hallidayboro, Ill.

18. (a) Signature of funeral director Baker Funeral Home
(b) Address Lutesville, Mo.

19. (a) 2 18-48 (b) Maria Ann Burroughs
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BOLLINGER
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR GRASSY
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17 1948 hour 2:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on dead and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Duration

Due to.

Due to.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 94A
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury 3

23. Signature John J. Myers (M. D. or other)
Address St. Louis, Mo. Date signed 2/17/48

RECEIVED

Sanitary Health Officer No. 4

Sanitary File Number 348-305

Sanitary No. 3-2-48

NOV 10 1954

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. E. Graham

Licensed Embalmer No. 4010

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.